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The Prevalence of Secondary Traumatic Stress Among Play Therapist

by

Juli A. Gottschall B.S.

MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, Minnesota
in Partial fulfillment of the Requirements for the Degree of
Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

This study examined the prevalence of secondary traumatic stress among play therapists; what factors increase the chances a play therapist will experience secondary traumatic stress; and whether play therapist who followed a directive model of play therapy experienced secondary traumatic stress (STS) differently than those who followed a non-directive model of play therapy. The sample was made up of 23 licensed registered play therapists who were recruited from five different chapters (Minnesota, Iowa, South Dakota, North Dakota, and Wisconsin) of the Association for Play Therapy. The Secondary Traumatic Stress Scale (Bride, 2004) was used to measure the STS symptoms. T-test and descriptive statistics were used to analyze the data. The result showed: 21% of the participants met the criteria for STS; the biggest risk factor for secondary traumatic stress was the severity of the client's trauma. Research implications are also discussed.

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Play Therapists and Secondary Traumatic Stress

Introduction

Social workers, counselors, therapists and other individuals who go into a helping professions like social work, nursing, and medicine go into it to help others and to make a difference. There is a lot to gain for individuals who are able to help others. Recently there has been an increase in research on some of the emotional effects that therapist and others in helping professions can experience as a result of helping individuals through a traumatic experience. Therapists in particular are trained to work with individuals who have gone through various traumas like rape, abuse and so forth. Therapists go through extensive schooling and trainings on the best theories and techniques to help their clients. They spend years learning ways to help their clients deal with the toughest of situations and experiences. A good therapist is able to meet the client where they are at. The therapist also needs to be able to handle hearing and taking in the traumatic and often horrifying experiences the client brings into therapy.

In recent years there has been an increase of research done on the emotional distress that is experienced by those in helping professions, especially those who work in trauma. The term that is most often used is secondary traumatic stress. According to The National Child Traumatic Stress Network secondary traumatic stress is identified as

the emotional distress that results when an individual hears about the firsthand trauma experiences of another. Its symptoms mimic those of post-traumatic stress disorder (PTSD). Accordingly, individuals affected by secondary stress may find themselves re-experiencing personal trauma or notice an increase in arousal and avoidance reactions related to the indirect trauma exposure. They may also experience changes in memory and perception; alterations in their sense of self-efficacy; a depletion of personal resources; and disruption in their perceptions of safety, trust, and independence. (2011, p.1)

Therapists have a high risk of experiencing secondary traumatic stress since helping others deal with their problems can be emotionally draining. Individuals who are trained to work with traumatized clients are given tools and told that proper self-care is extremely important when working with clients.

Working with children can be vastly different than working with adults so it is natural that their treatment would be different. There are many types of techniques and theories that therapists can choose from when deciding on the best way to treat their client. One therapy method that can be used when treating children is Play therapy.

Play therapy is an emerging therapy technique to work with children, play therapy is unique in the way a therapist goes about and works with the client. Most of the communication between the client and therapist is done through play. According to the Association for Play Therapy, play is the language of children. Children can communicate many things through their play.

The role of a play therapist is to be whatever the client needs the therapist to be. They are there to provide a safe place for the child to process whatever they need to. Many times through their play a child may play out with the therapist different traumas that they may have experienced. Through observing the child's play the therapist may experience the client's trauma. This is a factor that can put the play therapist at risk for secondary traumatic stress. This study will look at the prevalence of secondary traumatic stress (STS) in play therapists; what risk factors put therapists at risk of developing secondary traumatic stress and to see if there is a difference in individuals experiencing STS and the play therapy model they utilize.

This study was interested to know what the prevalence of secondary traumatic stress was among play therapists; what factors increased the chances a play therapist experiences secondary

traumatic stress; and if those who followed the non-directive or directive play therapy model experienced secondary traumatic stress differently.

This study evaluated three research questions. These included:

1. How prominent is secondary traumatic stress among play therapist? Based on the review of the literature the research hypothesis for this study is: No more than 62% of play therapist will experience secondary traumatic stress.
2. What factors increase the chances a play therapist will experience secondary traumatic stress? The research hypothesis for this study is: Based on therapist rankings, play therapists who primarily work with severely traumatized children are at higher risk of experiencing secondary traumatic stress.
3. Do non-directive and directive play therapist experience secondary traumatic stress differently? The research hypothesis for the study is: Directive play therapist will experience more secondary traumatic stress symptoms than non-directive play therapist. The null hypothesis for this study is: There is no difference between the way non-directive play therapist and directive play therapist experience secondary traumatic stress symptoms.

Literature Review

Terminology

In order to understand what secondary traumatic stress is one needs to define and distinguish it from the many terms that are interchangeably used within the literature. Secondary traumatic stress, burn out, vicarious trauma, compassion fatigue and compassion satisfaction are all terms that are interchangeably used when describing the emotional distress therapist may experience as a result of helping clients process their trauma. The National Child Traumatic Stress Network (2011) defined the following terms:

Burn-out - “characterized by emotional exhaustion, depersonalization, and a reduced feeling of personal accomplishment. While it is also work-related, burnout develops as a result of general occupational stress; the term is not used to describe the effects of indirect trauma exposure specifically.” (p.2)

Compassion fatigue- “less stigmatizing way to describe secondary traumatic stress, has been used interchangeably with the term.” (p.2)

Vicarious trauma- “refers to changes in the inner experience of the therapist resulting from empathic engagement with a traumatized client. It is a theoretical term that focuses less on trauma symptoms and more on the covert cognitive changes that occur following cumulative exposure to another person’s traumatic exposure.” (p.2)

Secondary Traumatic Stress-“refers to the presence of PTSD symptoms caused by at least one indirect exposure to traumatic material. Several other terms capture elements of this definition but are not all interchangeable with it”. (p.2)

While both vicarious trauma and secondary traumatic stress include PTSD symptoms there are few differences that are used to distinguish between secondary traumatic stress and

vicarious trauma. Vicarious trauma is a result of prolonged exposure to trauma while secondary traumatic stress can happen after one single experience with a client. In vicarious trauma there is more of a cognitive change whereas secondary trauma is more about the symptoms. In this study secondary traumatic stress and secondary trauma will be used interchangeably. This study will focus on secondary traumatic stress.

What is Secondary Traumatic Stress?

Secondary trauma is the emotional duress individuals can experience working with people who have experienced trauma. (The National Child Traumatic Stress Network, 2011, p.1). Secondary trauma can be brought on by prolonged work with clients or it can happen after one time of hearing a client's trauma. Individuals who develop secondary trauma experience similar Post-Traumatic Stress Disorder (PTSD) symptoms that their client has experienced. It is important to point out that while the individuals are experiencing PTSD symptoms they are not diagnosable for PTSD. The primary reason for this is that the individual did not experience the trauma first hand but were traumatized by hearing the client's account of the trauma. A few of the PTSD symptoms that can be experienced are sleep deprivation, recurring images or flashbacks, avoidance, hypervigilance, nightmares, intrusive daytime thoughts and exhaustion (Figly, 1995; Bride, Robinson, Yegidis, & Figley, 2004).

There are various professions that are at higher risk for experiencing secondary traumatic stress. Helping professions like nurses, firemen, policemen, therapist, child welfare workers and social workers are just a few of the professions that are at risk of experience secondary trauma. According to the National Child Traumatic Stress Network (2011) six to twenty six percent of therapist who work with a traumatized population are at a higher risk of developing secondary traumatic stress.

According to O'Halloran and Linton (2000) STS is a normal reaction when working with a client's trauma so most therapist will experience some form of secondary trauma in their work with clients. There were a few studies in the research that supported the idea that most therapist experience some form of secondary traumatic stress. In study done by Perlman and MacIain (1995) 62% of the therapist experienced secondary traumatic stress symptoms. A study done by Bride (2007) on social workers in various jobs and the prevalence of secondary traumatic stress showed that 70.2% of the participants reported experiencing at least one symptom of PTSD even though they did not meet the full criteria for full secondary traumatic stress. Regardless of whether an individual experience full secondary traumatic stress or just a few symptoms, the therapist is still affected by secondary traumatic stress symptoms.

The Effects of Secondary Trauma on Therapist

The profession of therapist is a very emotional demanding job. Individuals seek out therapists to help them work through various problems and traumas in their lives. Therapists are expected to listen and empathize with the client. Clients bring their traumas and the emotions and pain that comes with that into therapy with the therapist. The therapist needs to be able to handle these emotions without becoming overwhelmed by them. On a daily basis therapists hear the awful things people do to each other and the traumatic stories of their clients (Hesse, 2002). This is a factor that puts therapist at high risk for developing secondary traumatic stress.

The literature has shown that secondary trauma affects the therapists in many ways. Hesse (2002) summarized previous research and indicated that some of the symptoms therapists may experience as result of hearing their clients trauma include "disturbed sleep, flashbacks, irritability, anxiety, alienation, feelings of insanity." (p. 297). Secondary trauma can also cause therapists to become cynical and, avoidant (Pearlman & Saakvitne, 1995).

“Preoccupation with client’s traumatic material often interferes with a therapist ability to be fully conscious in his or her own personal experiences- causing dissociation from the self and creating distance from others.”(Hesse, 2002, p. 298). According to Simon (2012) in order for a therapist to be their most affective they need to be “passionately present, responsive, creative and flexible” (p. 8). If a therapist is experiencing trauma as a result of their client’s trauma story they will not be an effective therapist and the therapeutic relationship will be negatively affected.

The Effects of Secondary Trauma on the Therapeutic Relationship.

When a therapist is experiencing secondary trauma it not only affects them personally but professionally (Hesse, 2002). A therapist who is experiencing secondary trauma could unintentionally bring those feelings into the therapeutic relationship and cause further trauma or re-traumatize the client (Pearlman & Saakvitne, 1995). Pearlman and Saakvitne (1995) (as cited by, Hesse, 2002) state that the therapeutic relationship could be thwarted by the therapist’s secondary trauma if the client is aware of the therapist’s reaction to his trauma. The client may start avoiding certain topics so as not to disturb the therapist or the therapist may avoid the topics the clients want to discuss in order to avoid their feelings of “anxiety, anger, fear, or other strong feelings” (Hesse, 2002, p. 301). If this occurs then the needs of the client are no longer being met. An individual who is seeking help from a professional does not want and should not have to provide care to the therapist.

Secondary Traumatic Stress and Working with Children

According to the Center for Disease Control and Prevention (2013) 13%-20% of children suffer from mental disorders and those numbers are on the rise. The National Child Traumatic Stress Network (2011) reports that each year over ten million children in the United States experience varying traumas from abuse, violence, or national disasters. Professionals are needed

to help these young clients. The risk of burnout or job turnover is increased when a therapist who works with children is experiencing secondary traumatic stress (Motta, 2012).

Various studies mentioned that working with children can be more difficult than working with adults. In a study done by Beaton and Murphy (1995) various professionals reported feeling more vulnerability when working with a child. A study done after the terrorist attack in New York City (9/11) showed that therapist reported having a more difficult time dealing with the trauma of children compared to the trauma of adults (Pulido, 2012). Horwitz (2006) reported that child welfare workers reported feeling more trauma from hearing a client's trauma than from receiving threats. Doing therapy with children is different than doing therapy with an adult. There are various methods that can be used when it comes to doing therapy with a child. One model that seems to have become popular in the last few years is play therapy.

Play Therapy

Landreth (2002) described play therapy as:

Play therapy is defined as a dynamic interpersonal relationship between a child (or person of any age) and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child (or person of any age) to fully express and explore self (feelings, thoughts, experiences, and behaviors) through play, the child's natural medium of communication, for optimal growth and development. (p. 11)

Play is an important part of a child's life. According to Landreth (2002) "Play is the singular central activity of childhood, occurring at all times and in all places" (p.7). Play plays an important part in the development of the child. Through play a child is able to process a lot of

what is going on around in their world that they may not understand, in this play they are in control and this control is “essential to children’s emotional development and positive mental health” (Landreth, 2002, p.15)

Children think in a more concrete way and their abstract thinking is not really developed so exclusively talk therapy may not be the best way to work with children. Landreth (2002) suggest that in order to truly explore a child’s “emotional world” the therapist needs to move from his own “world of reality and verbal expression” to the “expressive world of children.” (p.7). According to the Association for Play Therapy “Play is the child’s language and toys are the child’s words. Play can be useful because it is safer for child to play their traumatic experiences than to discuss them since play is “pretend”. It is also safer for them because the child may be playing something out but they get to choose which role in the play they are.

Models of Play therapy

There are different forms of play therapy; non-directive / child centered play therapy; structured/directive play therapy; filial play therapy and psychoanalytic play therapy. Each of these models of play therapy are considered in the paragraphs below.

Child Centered Play Therapy / non-directive play therapy originates from Rogerian principles. Virginia Axline was Carl Roger’s student and she was greatly influenced especially by his person- centered therapy ideas (Guerney, 2001). A non-directive play therapy session is run in a room full of toys. With non-directive play therapy the child guides the session. He decides with which toys and games he will play. The therapist gives him free reign unless he is hurting himself or compromising the therapist. The client is allowed to be himself and is not challenged in the therapy. If the child does not want the therapist involved then they will not be. If the child wants them involved in the play then they will participate.

In a directive / structured play therapy the therapist plays a large role in therapy. The therapist is the “both the director and facilitator of the therapeutic process” (Jones, Casado, & Robinson, 2003, p.32). In this model the therapist guides the client and sets more boundaries than non-directive/ child centered play therapist do.

Filial play therapy is unique in that the parents are more involved in the play therapy. In Filial therapy the therapists train the parents so they are the ones in the play room with the child. This model is used to strengthen the relationship between the child and parent. Bratton, Ray, Rhine and Jones (2001) did a meta-analysis study of 94 research studies which focused on the efficacy of play therapy, filial therapy, and combined play therapy and filial therapy. Their findings showed that when parents were involved in the therapy play therapy was very affective.

Conceptual Framework

Constructivist Self-Development Theory (CSDT) is the framework this research was looked through. Trauma can affect each individual differently. In the CSDT there are five areas of “self” that are affected when trauma occurs (Saakvitne, Tennen & Afflect , pg 283). The first area is the frame of reference which is the way an individual understands the world around them (pg.283). The second are self-capacities is the way and individuals “recognize, tolerate and integrate affect and maintain a benevolent inner connection with self and others” (Saakvitne, et al.,pg. 283). The third area is ego resources, which is “necessary to meet psychological needs in mature ways; specifically, abilities to be self-observing, and use cognitive and social skills to maintain relationships and protect oneself” (Saakvitne, et al., pg., 283). The fourth area is central psychological needs that are “reflected in disruptive cognitive schemas in five areas: safety, trust, control, esteem, and intimacy (Saakvitne, et al., pg., 283). The last area is

perceptual and memory system which includes “biological (neurochemical) adaptations and sensory experience (Saakvitne, et al., pg. 283).

Methods

Sample

The sample was made up of 23 licensed play therapists. The participants were recruited through the Association for Play Therapy directory. Potential participants were identified from five different state chapters of the Association of Play Therapy including: Minnesota, Iowa, South Dakota, North Dakota and Wisconsin. The participants were made up of Registered Play Therapist Supervisors and Registered Play Therapists. Out of the 150 individuals who were sent the surveys 28 individuals started the survey and 23 three of them completed the survey. No other identifying information was gathered from the participants.

Protection of Human Subjects

Each participant received an email explaining the purpose of the study and a link to the survey (Appendix A). In accordance to the IRB regulations each participant was given a consent form that explained the purpose of the study; informed participant that they can end the survey whenever they chose without any fear of penalty; explained the measures that were taken to protect the confidentiality of the participants and the data. (Appendix B). The consent form was on the first page of the survey. The researcher designed the survey to begin only if the participants checked a box that stated they had read the consent form, were above 18 years old, and agreed to participate in the research study.

Design

The purpose of this study was to measure the prevalence of secondary traumatic stress in play therapists. A quantitative cross-sectional research design measured the play therapist's responses. This study used an online survey tool, which included one published measure and three other questions.

Measures

Bride, Robinson, Yegidis, and Figley (2004) developed the Secondary Traumatic Stress Scale (STSS) as a tool to specifically measure secondary traumatic stress symptoms that those in helping professions experience as a result of working with individuals who have experienced trauma. The STSS is made up of 17 questions that measure the frequency of arousal, intrusive and avoidance symptoms that the individual has experienced in the last seven days. The questions are asked using a 5-point scale with the answers varying from 1 (never) to 5 (very often) (Bride, Robinson, Yegidis, & Figley, 2004). Each question indicates an arousal, avoidance, or intrusion symptom that is seen in individuals with PTSD. There are five questions used to measure the intrusion symptoms; seven questions measure the avoidance symptoms and five questions assess the arousal symptoms. The survey can be found in Appendix (C)

Prominence of secondary traumatic stress in play therapist. The Secondary Traumatic Stress Scale (STSS) total score measured the overall experience of traumatic stress. Bride (2007) identified two methods for score interpretation. The first method is to develop a cut point that can be used to determine if the participants' scores are above or below the cutoff score in order to determine if they meet the criteria for secondary traumatic stress according to the scale. As suggested by Bride (2007) a cut of score of 38 was used to determine if individuals met the criteria for secondary traumatic stress. The second method Bride (2007) recommended was of dividing the total score of the STSS into different categories to provide a description of the level of STS participants' experienced. The Secondary Traumatic Stress Scale was also analyzed and divided into three separate subscales; intrusion subscale, avoidance subscale, arousal subscale.

Subscales. An intrusion subscale was created to measure the intrusive symptoms the participants reported. The intrusion subscale was created by combining the scores of the following statements; My heart started pounding when I thought about my work with clients (2); It seemed as if I was reliving the trauma(s) experienced by my client(s) (3); Reminders of my work with clients upset me (6); I thought about my work with clients when I didn't intend to (10); I had disturbing dreams about my work with clients (13).

An avoidance subscale was created to measure the avoidance symptoms the participants reported and the reliability of the subscale. . The avoidance subscale was created by combining the scores of the following statements; I felt emotionally numb (1); I felt discouraged about the future (5); I had little interest in being around others (7); I was less active than usual (9); I avoided people, places, or things that remind me of my work with clients (12); I wanted to avoid working with some clients (14); I noticed gaps in my memory about client responses (17).

An arousal subscale was created to measure the arousal symptoms that participants reported and the reliability of the scale. The arousal scale was created by combining the following questions; I had trouble sleeping (4); I felt jumpy (8); I had trouble concentrating (11); I was easily annoyed (15); I expected something bad to happen (16).

The study used two different methods to score the STSS. The first method was by using Bride's (2007) suggested method of using a cut point of 38. Individuals who scored above 38 met the criteria for STSS and participants who scored below 38 did not meet the criteria for STSS.

The second method that was used to score the STSS was using Bride's (2007) recommendation of dividing the total score of the STSS into different categories to provide a description of the level of STS participants experienced. Scores were interpreted as following:

scores at or below 28 were interpreted as little to no STS, scores between 28 to 37 are interpreted as mild STS, scores within the 38-43 range are interpreted as moderate STS, scores within 44 to 48 range are interpreted as high STS, and scores above 49 are interpreted as severe STS.

The researcher included three additional open-ended questions: Do you follow a non-directive play therapy model or a directive play therapy model? Possible responses were; directive, non-directive or other with the option of adding comments. The second questions was “How long have you been practicing play therapy?” The response options were categorical with the possible responses varied from zero to thirty years of experience. The third question was a ranking question “Rank the three factors you believe contribute to the development of secondary traumatic stress in play therapists”. The possible responses were severity of trauma in clients; part-time work schedule; fulltime work schedule; negative experiences of the client; and other with the option to fill in. The respondents were asked to rank the top three. Number one represents the most significant risk factor and number three indicates the least significant risk factor.

Data Collection

Data was collected using Qualtrics an online survey tool.

Data Analysis

How prevalent is secondary traumatic stress among play therapists? To answer this question, the participants were asked to fill out the Secondary Traumatic Stress Scale (2004) which measured the intrusion, avoidant, and arousal symptoms they had experienced in the last seven days. Descriptive statistics was used to measure the participant’s score on the STSS.

What factors increase the chances a play therapist will experience secondary traumatic stress? This study was interested to know what factors increased the chances a play therapist would experience secondary traumatic stress. The participants were asked to rank the top three risk

factors that they believed contributed to a play therapist experiencing secondary traumatic stress. A frequency distribution analysis was done on the factors the participants reported as being the highest risk factors that contribute to secondary traumatic stress among play therapists.

Do non-directive and directive play therapists experience secondary traumatic stress differently? To answer this question, a t-test compared the two groups of therapist (directive versus non-directive) using the results of the STSS as the independent variable. To evaluate possible differences in each of the subscales of the STSS, this researcher also ran additional t-tests with each of the sub-scales of the STSS.

Results

Research Questions

For each of the three research questions, the results are organized according to the research question.

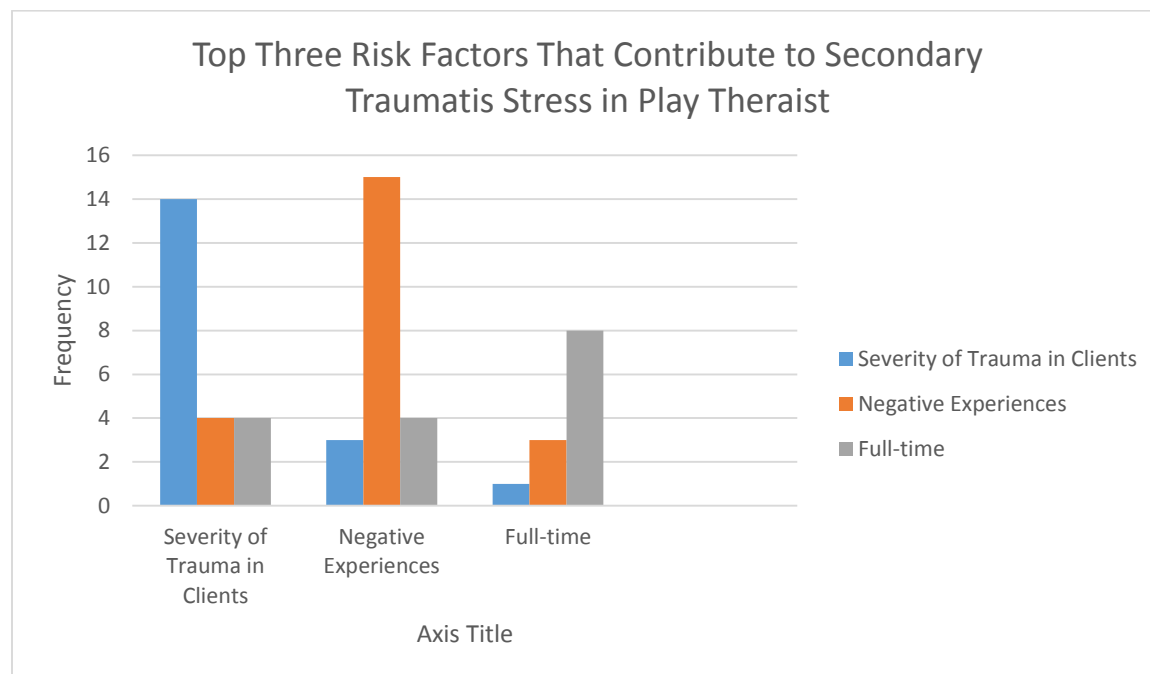
Prominence of secondary traumatic stress in play therapists. To answer this first question, the study used the total score of the STSS, which had an overall coefficient alpha of .91, which is well above the acceptable reliability threshold for applied research. To provide context for the score distribution of the STSS, this researcher followed Bride's (2007) recommendation of dividing the total score of the STSS into different categories to provide a description of the level of secondary traumatic stress (STS) participants experienced. Scores were interpreted as following: scores at or below 28 were interpreted as little to no STS, scores between 28 to 37 were identified as mild STS, scores within the 38-43 range were described as moderate STS, scores within 44 to 48 range were associated with high STS, and scores above 49 were interpreted as severe STS. Using Bride's (2007) categorical interpretation based on the study data presented the following results: 39.1% of the participants showed little or no STS; 34.6% had mild STS; 14.2% had moderate STS; 3.6% had high STS. None of the participants had severe STS. Table 1 includes these findings.

This study was interested in the prevalence of STS in play therapist. When considering the specific question of how many individuals displayed STS, the cut score interpretation is most pertinent. When considering Bride's (2007) cut score of 38, 21% of the sample indicated secondary traumatic stress, 79% had scores below the cut score of 38 on STSS, meaning that they would not be identified as experiencing STS.

Table 1. Frequency distribution

	Range				
STS	Little or No 17-28	Mild 28-37	Moderate 38-43	High 44-48	Severe 49 +
Percentage %	39.1	34.6	14.2	3.6	0

STS= Secondary Traumatic Stress

Factors That Could Increase the Chance of Developing STS.**Table 2. Therapist Ranking of Risk Factors**

Number one risk factor: Severity of trauma in clients. This nominal variable measures the respondent's responses to what they believe to be the most important risk factors that contributes to secondary traumatic stress in play therapist and is represented in Table 2. This variable is operationalized with the item: Severity of trauma in clients. The finding of this study in Table 2 show that 50% of the participants replied that the severity of trauma in clients was the most significant factor contributing to play therapists experiencing secondary traumatic stress. These

findings show that the majority of the participants consider the severity of trauma in clients to be the most significant risk to play therapist for experiencing secondary traumatic stress.

Number two risk factor: Negative experiences. This nominal variable measured what the participants believed to be the second most significant factor that contributes to secondary traumatic stress among therapists. The findings shown in the table above show that 53% of participants reported negative experiences as the second most influential factor in developing secondary traumatic stress.

Number three risk factor: Full-time work. This nominal variable measures what the respondents believe to be the third most significant risk factor that causes play therapist to experience secondary traumatic stress. The variable is operationalized with the item: “full-time”. The findings in this study show that 28.6% of the respondents believe that being a full-time therapist is the third riskiest variable that contributes to play therapist experiencing secondary traumatic stress.

Do non-directive and directive play therapist experience secondary traumatic stress differently? This study was interested to know whether directive play therapist and non-directive play therapist experienced secondary traumatic stress differently as a result of the model they followed.

Table 3. Frequency of therapeutic methods.

		Model			
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Directive	1	3.6	4.3	4.3
	Non-directive	11	39.3	47.8	52.2
	Other	11	39.3	47.8	100.0
	Total	23	82.1	100.0	
Missing	System	5	17.9		
Total		28	100.0		

As seen in Table 3 the data analysis revealed that out of the 23 participants only one followed a directive play therapy model. The remaining participants followed either a non-directive model or used a combination of both directive and non-directive models of play therapy. One participant reported they follow a Gestalt therapy model. The underwhelming response of play therapist who follow a directive play therapy model required a change in analysis. Since the data made it impossible to analyze the difference between the participants who reported non-directive model and directive model a new group was created from the participants. With the exception of the individuals who reported following a directive model of play therapy and a Gestalt model, the remaining participants who reported following both directive and non-directive models of play therapy were combined into the group “other”. Using the sub groups mentioned above; arousal subscale, intrusion subscale and avoidance subscale, differences between the groups were measured.

Table 4.

Group Statistics					
	Model	N	Mean	Std. Deviation	Std. Error Mean
Total	Non-directive	11	29.6364	8.13969	2.45421
	Other	10	31.6000	10.03549	3.17350

Table 5 T-test for total STSS scores.

	Levene's Test for Equality of Variances		t-test for Equality of Means		
	F	Sig.	T	df	Sig. (2-tailed)
Equal variances assumed	.597	.449	-.495	19	.627
Equal variances not assumed			-.489	17.387	.631

Tables 4 and 5 shows the results of the t-test comparing the total STSS scale scores of the respondents in the two groups. The respondents who reported a non-directive model had a mean

total scale score of 29.6. The respondents who reported an eclectic model had a mean total scale score of 31.6. The difference between these mean scale scores was 2.0. The t-test ($t(19) = -.49$, $p = .627$). Since the p-value is greater than .05, the results of the data are not statistically significant. As a result, the null hypothesis was accepted, meaning that there was no difference in the total scale score for the STSS between these two groups.

T-Test for Intrusion subscale. This second analysis considered if group differences existed for the intrusion subscale

Table 6.

Group Statistics					
	Model	N	Mean	Std. Deviation	Std. Error Mean
Intrusion	Non-directive	11	8.9091	2.62505	.79148
	Other	10	9.6000	2.71621	.85894

Table 7. T-test of intrusion subscale

Independent Samples Test						
		Levene's Test for Equality of Variances		t-test for Equality of Means		
		F	Sig.	t	df	Sig. (2-tailed)
Intrusion	Equal variances assumed	.022	.884	-.593	19	.560
	Equal variances not assumed			-.592	18.663	.561

Tables 6 and 7 show the results of the t-test comparing the total intrusion subscale scores of respondents in the two groups. The respondents who reported a non-directive model had a mean total intrusion subscale score of 8.9. The respondents who reported an eclectic model had a mean total scale score of 9.6. The difference between these mean subscales scores was .7. The t-test ($t(19) = -.59$, $p = .560$). Since the p-value is greater than .05, the results of the data are

not statistically significant. As a result, the null hypothesis was accepted, meaning that there was no difference in the total scale score for the intrusion subscale between these two groups.

T-Test for Avoidance Subscale. The third assessment considered if group differences were evident when considering the avoidance subscale of the STSS.

Table 8.

Group Statistics					
	Model	N	Mean	Std. Deviation	Std. Error Mean
Avoidance	Non-directive	11	12.0909	3.53425	1.06562
	Other	10	12.9000	5.04315	1.59478

Table 9. T-test for avoidance subscale

Independent Samples Test						
		Levene's Test for Equality of Variances		t-test for Equality of Means		
		F	Sig.	t	df	Sig. (2-tailed)
Avoidance	Equal variances assumed	2.394	.138	-.429	19	.673
	Equal variances not assumed			-.422	15.966	.679

The table above shows the results of the t-test comparing the total avoidance subscale scores of respondents in the two groups. The respondents who reported a non-directive model had a mean total avoidance subscale score of 12.09. The respondents who reported an eclectic model had a mean total scale score of 12.9. The difference between these mean subscales scores was .81. The t-test ($t(19) = -.429, p = .673$). Since the p-value is greater than .05, the results of the data are not statistically significant. As a result, the null hypothesis was accepted, meaning that there was no difference in the total scale score for the avoidance subscale between these two groups.

T-Test for Arousal sub-scale. The final analysis considered whether differences appeared

between these two groups for the arousal subscale.

Table 10.

Group Statistics					
	Model	N	Mean	Std. Deviation	Std. Error Mean
Arousal	Non-directive	11	8.6364	2.73030	.82322
	Other	10	9.1000	2.80674	.88757

Table 11 **Independent Samples Test**

		Levene's Test for Equality of Variances		t-test for Equality of Means		
		F	Sig.	t	df	Sig. (2-tailed)
Arousal	Equal variances assumed	.001	.975	-.384	19	.706
	Equal variances not assumed			-.383	18.694	.706

The table above shows the results of the t-test comparing the total avoidance subscale scores of respondents in the two groups. The respondents who reported a non-directive model had a mean total arousal subscale score of 8.6. The respondents who reported an eclectic model had a mean total scale score of 9.1. The difference between these mean subscales scores was .5. The t-test ($t(19) = -.384, p = .706$). Since the p-value is greater than .05, the results of the data are not statistically significant. As a result, the null hypothesis was accepted, meaning that there was no difference in the total scale score for the arousal subscale between these two groups.

Discussion

This study had three purposes, to examine the prevalence of secondary traumatic stress in play therapist; to determine if directive play therapist experience more secondary trauma than play therapist who follow a non-directive model of play therapy; and to determine what risk factors increased the likelihood of a play therapist experiencing secondary traumatic stress. There is not an abundant amount of research done on secondary traumatic stress in play therapist. This research was done to in order to help fill this research gap. While there were no significant findings in this study it did show that the STSS is very reliable.

Prevalence of Secondary Traumatic Stress in Play Therapist.

Using an earlier study by Pearlman and McIan (1995) it hypothesized that 62% of the participants would experience STS. That was not the case. While many of the participants reported various degrees of STS only 21% met the full criteria for full STS. It is important to point out that using Bride's (2007) second interpretation of dividing clients into categories depending on the range of STS yielded different results. Using that method the study showed that 52.4% of the participants experienced some degree of secondary traumatic stress. According to O'Halloran and Linton (2000) STS is a normal reaction when working with a client's trauma so most therapist will experience some form of secondary trauma.

There are a few reasons why there were was such a difference in this study than in Pearlman and McIan's (1995) study. The participants in this study was made up of 23 play therapists compared to the therapists in Pearlman and McIan's (1995) study which was made up of 188 participants who identified as trauma therapists. The sample in this study was smaller and some of the participants may not have had a lot of experience working with traumatized clients.

What factors increase the chances a play therapist will experience secondary traumatic stress?

The reported findings indicated that the severity of the client's trauma; the negative experiences of the play therapist's; and full-time hours were the top three factors that put play therapist at greater risk for developing secondary traumatic stress. This supports

The current literature that indicates that an individual's negative personal experience and the more severe the trauma the more likely one is to develop secondary traumatic stress. It should be reported the one small finding this research found. When asked to report what they believe to be a risk factor 10% of the participants added lack of supervision / support as a factor that could increase the chances of a play therapist experiencing STS.

In the literature it was suggested that if the therapist had trauma in their past then they were at higher risk of experiencing secondary traumatic stress. The reason this may not have shown in this study could be because that option was not added in the risk factors by the researcher or the participants.

Do non-directive and directive play therapist experience secondary traumatic stress differently?

This study hypothesized that play therapist who followed a directive play model would experience more STS than therapist who followed a non-directive play therapist. Because of the lack of response from play therapist who follow a directive model of play therapy this research questions was not answered. Instead differences in the subscales between participants who followed a non-directive model of play therapy and participants who followed a more eclectic model were compared. The findings of these analyses were all non-significant, meaning that

these two groups of practitioners displayed similar levels of overall STS and similar levels of STS for each of the sub-scales.

There may have been a few reasons why this study did not produce any significant results between the two groups. If the sample size were larger and if more directive play therapist had responded then the results may have been different.

Implications for Social Work Practice

Most if not all social workers will at one point in their career work with a client who has some form of trauma in their lives and many who have endured various traumas. According to O'Halloran and Linton (2000) STS is a normal reaction when working with a client's trauma so most therapist will experience some form of secondary trauma. Even though this study did not yield significant finding it did show that many of the participants experienced some secondary traumatic stress symptoms even if they were not severe. In order for social workers, play therapist and others in helping professions to be effective helpers they need to be aware of secondary traumatic stress and the ways it can affect them personally and professionally. For social workers it is an ethical issues. According to the National Association of Social Workers (1996) "Social workers should not allow their own personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties to interfere with their professional judgment and performance or to jeopardize the best interest of people for whom they have professional responsibility." (p. 26). It is a social workers ethical responsibility to make sure their issues do not negatively affect their work with clients.

Research Implication

Due to the limitation of this study there are multiple areas that could further be researched on. The sample size of the study was small. A larger sample may produce better

findings. A small unexpected findings showed that some 10% of the participants reported lack of supervision and support as the number one factor that increased a play therapist chance of experiencing secondary traumatic stress. Further research can be done to determine if support and supervision plays a role in preventing or reducing secondary traumatic stress in play therapist.

While researching the literature the researcher struggled to find literature on secondary traumatic stress because many studies varied on their definitions and at times vicarious trauma was combined with it. Further research could be done to further clarify the terminology. Another area that could be further research is on ways to prevent secondary traumatic stress. There is some literature on what secondary trauma is and how to best cope with it but this researcher did not see any studies on how secondary traumatic stress can be prevented.

Limitations of the Study.

This study had a few limitations. First off, terminology throughout the articles for the literature review were not consistent when defining and distinguishing between secondary traumatic stress, vicarious trauma and burn-out. A lot of the literature used secondary traumatic stress and vicarious trauma interchangeably. Another limitation to this study was the sample size. Out of the 150 participants that were sent the survey only 28 responded to the survey and only 23 participants completed the survey. Another limitation to this study was the lack of responds from participants who follow a directive model of play therapy. This study was also limited by the lack of research on the effects of trauma on play therapist.

Conclusion

In conclusion, this study set out to learn what the prevalence of secondary traumatic stress was among play therapist; what were some of the factors that put play therapist at risk for

experiencing STS; and if play therapist who followed a directive model of play therapy experienced STS different than play therapist who followed a non-directive model of play therapy. This study showed that secondary traumatic stress was present in the participants but not as high percentage that the study hypothesized. This study showed that the client's severity of the trauma, negative experiences and full-time work are the top three risk factors of a play therapist experiencing secondary traumatic stress. This study was done to help with the research gap on secondary traumatic stress in play therapist.

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Appendix A

(Initial Email sent out with link to survey)

Hello,

My name is Juli Gottschall. I am graduate student at University of St. Thomas in St. Paul, Minnesota. I am in the final year of my Masters in Social Work program. The MSW program requires each clinical student to complete a research project. I obtained your information from the Association of Play Therapy website. You have been invited to participate in this study because you are a registered play therapist. I am researching secondary traumatic stress in licensed play therapist. There are no personal benefits in participating with this study. Below is the link to the survey. The survey will take less than 20 minutes. All data will be confidential and protected by a password that only I will know.

Thank you,

Juli Gottschall

jagottschall@stthomas.edu

APPENDIX B

UNIVERSITY of ST. THOMAS
MINNESOTA

Consent Form***Secondary Traumatic Stress in Play Therapist*****839868-1**

You are invited to participate in a research study about play therapist and the secondary traumatic stress they experience as a result of working with children. I invite you to participate in this research. You were selected as a possible participant because you are a licensed registered play therapist. You are eligible to participate in this study because you are a registered licensed play therapist who has experience working with children in a play therapy setting. The following information is provided in order to help you make an informed decision whether or not you would like to participate. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by Juli Gottschall, a graduate student at the School of Social Work, St. Catherine University/University of St. Thomas. This study was approved by the Institutional Review Board at the University of St. Thomas. This study is being supervised by Renee Hepperlen PhD, LICSW, a faculty member at the University of St. Thomas.

Background Information

The purpose of this study is to better understand secondary traumatic stress in play therapist.

Procedures

If you agree to participate in this study, I will ask you to do the following things: Answer the 20 question survey that I have attached a link to in this email. The survey will take between 15-20 minutes to complete. Once you have completed the survey click the submit button. My research advisor and I will be the only ones with access to the data. All data will be kept confidential and access to it will require a password. I will present and write a report that includes all my findings that will be published online.

Risks and Benefits of Being in the Study

The study has risks.

The study holds minimal confidentiality breach risks. The researcher is collecting minimal information that could potentially identify participants. In order to minimize this risk the researcher will not be collecting any names and survey tools do not link to any email addresses.

The study holds minimal risk of recalling traumatic or distressing events. Participating in this study may cause some emotional distress as the study is asking you to recall traumatic or distressing events. In order to minimize this risk the researcher will provide links to resources to help the participants who experience any distress as a result of recalling traumatic or distressing events.

(<http://www.apapracticecentral.org/ce/self-care/acca-promoting.aspx>,
<http://www.goodtherapy.org/blog/secondary-trauma-therapist-guide-0814135>)

&

The direct benefits you will receive for participating are: There are no direct benefits for participating in this study.

Privacy

Your privacy will be protected while you participate in this study. All emails and email addresses will be deleted immediately after the surveys are sent out.

Confidentiality

The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you. The types of records I will create include email records, email address records and research records. Email records and email address records will be kept in a password protected computer. The email records and addresses will be deleted immediately after the survey is sent out to the participants. Research records will be kept in a password-protected data base. My research advisor and I will be the only people to see the data. In order to keep the research data de-identified the survey program will be set up to anonymize the responses.

Institutional Review Board officials at the University of St. Thomas reserve the right to inspect all research records to ensure compliance.

Voluntary Nature of the Study

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with the University of St. Thomas. There are no penalties or consequences if you choose not to participate. If you decide to participate, you are free to withdraw at any time without penalty or loss of any benefits to which you are otherwise entitled. Should you decide to withdraw, data collected about you will not be used. To withdraw from this study, please close your browser. Once the survey is submitted, it will be impossible to withdraw data due to the nature of the anonymous survey.

Contacts and Questions

My name is Juli Gottschall. You may contact me with any questions you have now and any time during or after the research procedures. If you have questions later, you may contact me jagottschall@stthomas.edu You may also contact my research advisor at [REDACTED] or [REDACTED] You may also contact the University of St. Thomas Institutional Review Board at 651-962-6035 or muen0526@stthomas.edu with any questions or concerns.

Statement of Consent

I have read the above information. I consent to participate in the study. I am at least 18 years of age

_____ Yes, I agree to participate

_____ No, I do not want to participate.

Appendix C Survey

Q1 I agree to participate in this study.

Yes(1)
No (2)

Q2 I was selected as a potential study participant, because I hold a professional license and have worked at least one year as a play therapist.

True (1)
False (2)

Q3 I will be paid to participate in this study.

True (1)
False (2)

Q4 I can choose to end the survey at any time without fear of penalty.

True (1)
False (2)

Secondary Traumatic Stress Scale

The following is a list of statements made by persons who have been impacted by their work with traumatized clients. Read each statement then indicate how frequently the statement was true for you in the past **seven (7) days** by selecting the corresponding number next to the statement.

NOTE: "Client" is used to indicate persons with whom you have been engaged in a helping relationship. You may substitute another noun that better represents your work such as consumer, patient, recipient, etc.

	Never (1)	Rarely (2)	Sometimes (3)	Often (4)	Very Often (5)
1. I felt emotionally numb...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. My heart started pounding when I thought about my work with clients....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. It seemed as if I was reliving the trauma (s) experienced by my client (s)...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. I had trouble sleeping...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. I felt discouraged about the future...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Reminders of my work with clients upset me...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. I had little interest in being around others...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8 I felt jumpy...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. I was less active than usual...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. I thought about my work with clients when I didn't intend to...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. I had trouble concentrating...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. I avoided people, places, or things that reminded me of my work with clients...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. I had disturbing dreams about my work with clients...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. I wanted to avoid working with some clients...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. I was easily annoyed...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. I expected something bad to happen...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. I noticed gaps in my memory about client sessions...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Q18 Do you follow a non-directive play therapy model or a directive play therapy model?

- ☐ Directive Model
- ☐ Non-Directive Model

Q19 How long have you been practicing play therapy?

Q 20 . Rank the top three risk factor you believe contribute to the development of secondary trauma in play therapists. Number one represents the most significant risk factor whereas number three indicates the least significant risk factor.

- ☐ Severity of trauma in clients
- ☐ Part-time
- ☐ Full-time
- ☐ Negative Experiences
- ☐ Number of hours working as a play therapist
- ☐ Other _____